MINUTES
of the
SEVENTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

December 19-20, 2013
Room 307, State Capitol
Santa Fe

The seventh meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, at 8:40 a.m. on Thursday, December 19, 2013, in Room 307 of the State Capitol in Santa Fe.

Present
Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Nora Espinoza
Rep. Doreen Y. Gallegos
Sen. Mark Moores (12/19)
Sen. Benny Shendo, Jr.

Absent
Sen. Gay G. Kernan
Rep. Terry H. McMillan

Advisory Members
Sen. Craig W. Brandt
Sen. Jacob R. Candelaria
Rep. Nathan "Nate" Cote
Rep. Miguel P. Garcia
Sen. Daniel A. Ivey-Soto
Rep. Sandra D. Jeff (12/19)
Rep. Linda M. Lopez (12/20)
Sen. Cisco McSorley
Sen. Bill B. O'Neill
Sen. Mary Kay Papen (12/19)
Rep. Vickie Perea (12/19)
Sen. Nancy Rodriguez
Sen. Sander Rue
Rep. Edward C. Sandoval
Sen. William P. Soules
Rep. Elizabeth "Liz" Thomson

Rep. Phillip M. Archuleta
Sen. Sue Wilson Beffort
Rep. Paul A. Pacheco
Sen. Lisa A. Torraco

Guest Legislators
Rep. Eliseo Lee Alcon
Rep. Thomas A. Anderson
Sen. Carlos R. Cisneros

Sen. Timothy M. Keller (12/19)

(Attendance dates are noted for members not present for the entire meeting.)

Staff
Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS
Branden Ibarra, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Thursday, December 19

Welcome and Introductions

Representative Madalena welcomed guests to the meeting and asked members and staff to introduce themselves.

Approval of Minutes

A motion was made and seconded for approval of the minutes from the November 6-8, 2013 meeting of the LHHS. Representative Perea offered one point of clarification: she had not yet been appointed to the legislature as of November 6-8, 2013, and her name was mistakenly included among those marked "Absent" in the minutes for those dates. She asked that her name be stricken from the "Absent" column of advisory members. With this correction, the motion of approval or the minutes passed unanimously.

Another motion was made to approve the minutes of the Disabilities Concerns Subcommittee meeting on November 4 and the Behavioral Health Subcommittee meeting on November 5. This motion was seconded and passed with no objections.

Computer Adaptive Testing — Mental Health Suicide Prevention Solution

Steve Trubow, a medical engineer with Olympic Behavior Labs in Port Angeles, Washington, introduced Robert Gibbons, Ph.D., a professor of biostatistics at the Center for Health Statistics, University of Chicago, and Jan Fawcett, M.D., a professor in the Department of Psychiatry at the University of New Mexico (UNM) Health Sciences Center (HSC). The panelists discussed a new screening tool, computerized adaptive testing for mental health (CAT-MH)(see handout). Providing a live demonstration for committee members, Dr. Gibbons showed how a brief screening of approximately two minutes can identify individuals who are severely

depressed and at high risk of suicide. The program, which has been the focus of a 10-year National Institutes of Health grant in New Mexico and West Virginia, is a simple diagnostic screening that can be used with accuracy and precision anywhere there is an internet or smart phone connection, Dr. Gibbons said. New Mexico and West Virginia were selected for the project because both states have a high number of medically underserved areas, high populations of veterans, challenges in geography and a lack of technical innovation, he said. Untreated, undiagnosed depression is the biggest risk for suicide, and the combination of anxiety and depression is particularly deadly.

With the federal Patient Protection and Affordable Care Act's (PPACA's) emphasis on the use of primary care to improve health outcomes, this brief screening set up in a primary care provider's office can become an important tool, Dr. Gibbons said. The severity of the score determines whether that individual should be further screened for risk of suicide. Being able to identify those persons at highest risk means that they can be more quickly referred for specialized mental health services. The CAT-MH will, in the long term, not only save lives but save millions of health care dollars by reducing hospitalizations and emergency room visits, he said. There is a Spanish version of the screening, and a child's version is under development. Cultural differences that would be critical among Native American populations are being explored through another grant at the University of Chicago, Dr. Gibbons said. Plans are under way to implement this testing in a pilot project in Taos.

Questions and Comments

One committee member asked about the possibility of using this screening in other care settings. Dr. Gibbons agreed that this may hold promise, such as in detention centers, but the model is designed to be used in partnership with states through Medicaid and Medicare. In New Mexico, the project has formed a partnership with the UNM HSC Department of Psychiatry. When a problem is identified in an individual, Dr. Fawcett said, it needs to be in a setting where immediate intervention can take place. Another member suggested using the test to screen for posttraumatic stress disorder among veterans, and Dr. Gibbons said that his team is actively pursuing this possibility and has been talking with the New Mexico National Guard. Mr. Trubow said there have been meetings in Gallup and San Juan County, where there is a high population of young Native Americans who have the highest suicide risk. The screening might be given through the schools, Mr. Trubow said. Dr. Gibbons suggested the possibility of having a kiosk in Navajo Nation chapter houses; internet would not be needed, he said; only an electrical outlet is required. A member noted that overcoming the stigma of seeking mental health help is a big problem culturally among Native Americans. Dr. Fawcett agreed, noting that this problem was beyond the scope of the project.

A member asked if anything could be done about the continuing problem of suicide jumpers at the Rio Grande Gorge bridge just northwest of Taos, which is very costly to the county's emergency and technical response teams. Dr. Fawcett responded that physical barriers might be helpful, but in the long run there probably is not much that can be done about people who drive from out-of-state to commit suicide at a specific location. The key is to implement

earlier diagnostic intervention with those individuals, before they have reached the decision to drive to Taos.

Native American Suicide Prevention Clearinghouse

Panelist Sheri Lesansee, program manager of the Native American Behavioral Health program at the UNM Center for Rural and Community Behavioral Health, introduced herself and the Honoring Native Life program, a Native American Suicide Prevention Clearinghouse and Technical Assistance program established in 2011 by Senate Bill 417 (see handout). Senate Bill 447 in 2013 created a Native American Suicide Prevention Advisory Council with 11 voting members who will assist in developing policies, rules and priorities for the clearinghouse. Ms. Lesansee reported that great progress has been made, with eight voting members of the council's appointments having been approved and three others pending approval. The web site, www.honoringnativelife.org, has been redesigned. A community summit was held in May and planning is in place for a statewide youth and family coalition to be formed, Ms. Lesansee told the committee. Community engagement activities have included participation in training with the Albuquerque Area Indian Health Service and the Inter-Tribal Council on Substance Abuse and contact with the Albuquerque Indian Center, the All Indian Pueblo Council, Acoma Behavioral Health Clinic, Circle of Life — Eight Northern Pueblos, Inc., the Dine Ba Hozho Coalition in Shiprock, the Navajo Nation and the Mescalero Apache Tribe.

Ms. Lesansee was accompanied at the committee presentation by Doreen Bird, M.P.H., a community-based research specialist with the UNM Center for Rural and Behavioral Health; Caroline Bonham, M.D., a psychiatrist and director of the center; and two students: Kaylee Pesina of the Pueblos of Isleta and Laguna and Kateri Daw of the Navajo Nation, both members of the newly formed Honoring Native Life Youth Council. The youth council was established to broaden and deepen communication between youths and adults, she said, and to develop training and strategies for suicide prevention. Members of the youth council developed a video that can be seen on the web site and are planning to host a statewide Youth Council Summit in 2014. The youth group will address gun safety, anti-bullying efforts and ways to overcome stigma, among other related topics.

Health Care Procurement and Transparency Legislation

Senator Papen and Ms. Mathis directed the committee members' attention to Item 29 (202.195404.1) in the list of bills for endorsement consideration for the 2014 legislative session (see Appendix A). Ms. Mathis explained that because of recent changes to Human Services Department (HSD) rules that go into effect January 1, 2014, any right to an adjudicatory hearing for a person who is the subject of a referral to the attorney general for a credible allegation of fraud (CAF) is unequivocally eliminated. What this bill does in Section 2 is amend the Medicaid Provider Act by adding a definition to CAF in terms of the process used by the HSD, not in terms of what the provider is alleged to have done. Section 3 of this bill makes a CAF determination by the HSD a final decision from which a provider can immediately appeal in district court under Section 39-3-1.1 NMSA 1978. What this does, Ms. Mathis said, is offer judicial review of the integrity of the process that was used to make the determination of a CAF. Section 4 of this bill

adds language from federal law and guidance that, in the absence of evidence to the contrary, mere errors found during the course of an audit, or billing or processing errors, do not constitute Medicaid fraud.

Questions and Comments

In response to a member's question about injunctive relief being denied to the behavioral health providers who were subject to the HSD audit conducted by Public Consulting Group (PCG), Ms. Mathis explained that the behavioral health provider's claims were brought in federal court alleging lack of due process and that process is continuing. A committee member stated his opinion that this bill does not go far enough. The providers who were referred by the HSD have gone out of business and no longer have the finances to pursue their interests in court, he said. The resulting disruption of behavioral health services should not have been allowed, the member continued; the HSD should have been required to attempt other remedies before choosing the "nuclear option". Several other committee members thanked Senator Papen for this legislation, and one member added that he hopes the debate this legislative session will be centered on the principle that, before the state can take away a person's pursuit of life and liberty, due process must be provided.

A motion was made for committee endorsement of this bill; it was seconded and approved by a majority of voting members.

Health Care Procurement

Senator Keller presented Item 3 (202.194655.2) in Appendix A, which would eliminate the health care exemption to the Procurement Code; clarify that an investigation of alleged health care overpayments or fraud is not an emergency condition justifying an emergency procurement; require a public body to contract through normal procurement procedures for audit services to investigate alleged overpayments or fraud and to contract for temporary on-call health care or other services necessitated by a suspension of payments pursuant to a determination of a CAF; and give the attorney general, state auditor and the Legislative Finance Committee standing to seek judicial review of certain purchasing practices. The bill also makes an appropriation of $100,000 from the general fund to the Office of the State Auditor to compile and maintain a list of audit firms approved to conduct audits of state and federal health care programs, and the bill declares an emergency.

One member commented that, over time, the legislature has allowed increasing authority to the executive branch and should not be surprised when things like the HSD's emergency contracts for the PCG audit, and its subsequent hiring of Arizona agencies, happen that bypass the Procurement Code. Another member asked why, if the HSD knew about the need for supplemental providers back in November, it was deemed an emergency in March.

A member moved that this legislation be endorsed by the committee; the motion was seconded and endorsed with a majority vote.

Health Care Cost Commission Amendment to the Constitution of New Mexico

Senator Keller also presented Item 22 (202.195269.2) of Appendix A, a Senate Joint Resolution proposing to amend Article 5 of the Constitution of New Mexico to create a Health Care Cost and Quality Transparency Commission to promulgate and enforce standards and regulations to ensure transparency of health care costs and other financial and quality data for use by consumers, taxpayers and policymakers. A motion was made to endorse the legislation; it was seconded and passed with a majority vote.

Medicaid Disability Services Oversight Council

Senator Keller then presented Item 5 (202.194697.1) of Appendix A, a senate joint memorial that would direct the New Mexico Legislative Council to establish a Medicaid Disability Services Oversight Council. Senator Keller was joined at the table by disabilities advocate Noni Sanchez, who told legislators that she has long advocated for just such a council that would bring stakeholders together, and she urged endorsement of the memorial. A member moved that the memorial be endorsed by the committee; the motion was seconded and passed with a majority vote.

Brain Injury Services

Senator Keller also presented Item 4 (202.194686.4) of Appendix A. This bill would enact new sections of the Group Benefits Act, the New Mexico Insurance Code, the Health Care Purchasing Act, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law to require coverage for services related to brain injury.

Glenn Ford, advocate and former board member of the New Mexico Brain Injury Alliance (see handout), spoke in favor of this legislation, describing his own difficult recovery following a brain injury. After being sent home from the hospital, Mr. Ford said, he continued to struggle, eventually losing his job, his insurance (most coverage is nonexistent beyond the acute stage of treatment, he said) and the support of family to the situation. Eventually, Mr. Ford was accepted by an acute care facility out of state where he was treated in a group setting for six months. During the past year, Mr. Ford said, three individuals with brain injury that he knew through the alliance have been lost to suicide. He advises anyone in New Mexico with a brain injury to leave the state for treatment.

Mark Quigley, chief executive officer (CEO) of Mentis Neuro Rehabilitation in Houston, also spoke in favor of this legislation. Mentis Neuro Rehabilitation treats brain injury patients with a multidisciplinary approach that addresses many of the behavioral and communication issues that often accompany brain injury, Mr. Quigley said. Without this kind of comprehensive treatment, most patients will be placed in a nursing home, regardless of age, he said. With dedication and advanced treatment, many patients are able to return to their former lives. These are rehabilitative services, Mr. Quigley said; they are not custodial or assisted-living services. The legislation being proposed has similar language to laws that have been passed in Texas and Ohio, Mr. Quigley said.

A member moved to recommend the legislation for endorsement by the committee; the motion was seconded and passed with a majority vote.

New Mexico Dental Association (NMDA) Update

Thomas J. Schripsema, D.D.S., chair of the NMDA Council on Government Affairs, presented his organization's "Oral Health Focus 2020", a comprehensive approach to resolving barriers that challenge good oral health in New Mexico, where tooth decay is the most common chronic disease among children. This approach identifies issues and creates policy, practice and funding objectives that will provide long-term savings to the state and to individuals, Dr. Schripsema said. The NMDA plan has four "areas of vision", he said: 1) prevention and public health; 2) effective funding; 3) education; and 4) practice and work force changes. The plan urges a statewide incentive program for community water fluoridation, a phase-out of the gross receipts tax on dental services and a phased plan to establish a dental school in New Mexico. Grant funding should be increased for all New Mexico students accepted into dental schools, he said, and loan repayment scholarship programs should be expanded in exchange for practice in highly underserved areas. The plan urges more training of community dental health coordinators (CDHCs) and suggests that a demonstration project on alternative mid-level work force models be undertaken for use in underserved communities. Dr. Schripsema also described to committee members the success of a pilot project at Hidalgo Medical Services in Grant County that utilized a CDHC and another project funded by the American Dental Association (ADA) that is collaborating with Indian tribes to improve the oral health of Native Americans. On the latter project, Stephanie Poston of the Pueblo of Sandia described the progress of prevention and education efforts currently under way.

Questions and Comments

A member asked why it is so difficult to get dentists to serve in frontier communities. Dr. Schripsema said that Medicaid does not pay enough to support a dental practice in these areas, and recent graduates of dental school have so much debt that they have to establish a reliable cash flow elsewhere. Another member asked for clarification on what a CDHC does in comparison to a dental therapist. A dental therapist performs irreversible procedures, whereas the CDHC's tasks are largely preventative and palliative, Dr. Schripsema said. A member asked what point there is in having a CDHC if there are no services to coordinate. Dr. Schripsema said the barrier to accessing dental care is lack of funding, and the assumption that there are not services available is not true — if the demand is there, the services will follow.

A committee member who is a former governor of the Pueblo of Jemez said he is looking for a long-term solution to the problem of so many children living with dental pain, which interferes with learning. The Alaska model of utilizing mid-level dental therapists is a native solution to a native problem, the member continued, and when the ADA sued the tribes in Alaska to try to prevent the dental therapy model, it also insisted on changes in the federal Indian Health Care Improvement Act and the PPACA. Now tribes cannot do what they want on their own lands and need to ask permission, the member said.

Dental Therapist-Hygienist Legislation

Pamela K. Blackwell, an attorney and project director of Oral Health Access for Health Action New Mexico, described the state as being thirty-ninth in the nation in the number of dentists per 1,000 residents. Other factors also point to an accelerating crisis, she said, including the fact that only one-half of the state's dentists accept Medicaid patients and the recent Medicaid expansion promises dental services for as many as 170,000 additional New Mexicans. Ms. Blackwell provided a PowerPoint presentation (see handout) and other support material (see handouts) regarding revised dental therapist-hygienist legislation being proposed by her organization. The dental therapist-hygienist model builds on the strengths of New Mexico's work force, Ms. Blackwell said, and provides an exceptional opportunity to invest in the community. Existing resources can be utilized at schools that are already located where the need exists, Ms. Blackwell said, and federal funds would be available for training. This is a health issue that demands a solution, she concluded.

Kristen Christy, executive director of the Union County Network in Clayton (see handout), described her organization's unsuccessful efforts to recruit a dentist. The network's extended rural community of approximately 4,000 people has been without a dentist or a dental hygienist for 12 years, she said, and currently, individuals must take an entire day off work to drive many hours for dental care in Dalhart or Amarillo, Texas, or Raton, New Mexico. Many people delay oral care, she said, and end up in the emergency room with septic conditions. The community has received a $500,000 grant for a health and dental clinic, but cannot find a dentist. Ms. Christy said that the dental therapist model being proposed is one that would work in her community; patients could keep their dental records locally and the network could nominate local students to attend dental therapist programs. This is a long-term solution for the community, she said.

Mary Altenberg, executive director of Community Dental Services (CDS) in Albuquerque and former chief of the Health Systems Bureau of the Department of Health (DOH), told committee members that the current system of dental care in New Mexico simply is not adequate. The CDS operates three clinics that serve more than 11,000 persons throughout the state (see handout) and is one of only a few that will serve low- and no-income patients. The need is huge, she said, and it only continues to grow. To meet future demand, the state will need mid-level providers for routine treatment. The dental therapist model being proposed for New Mexico could become part of the dental team at the CDS, Ms. Altenberg said, and CDS clinics could become training and education sites for students from underserved communities. Dental therapists could be employed at the CDS after graduation, she said, generating cost-savings for the clinics and helping to increase access to services for the growing number of patients. It is not a question of "if", Ms. Altenberg asserted, but "when".

Questions and Comments

A committee member asked Ms. Blackwell what has changed in the dental therapist-hygienist proposal from the original one put forth several years ago. The hygiene-based model is new, Ms. Blackwell said. Apparently, there is a glut of hygienists in Albuquerque who cannot practice in outlying areas because they must be supervised, she said; this dental therapy model

would expand the geographic area that a hygienist could serve. The legislation provides for a new code, not an addition to the existing dental code, and requires student sponsorship by a community and emergency training, which would allow practice in schools and at Indian Health Service sites. Ms. Blackwell disparaged a member's suggestion that dental therapy be rolled out in the form of a pilot project or on tribal lands only; to segregate it would be slowing a much-needed solution for the rest of the state, she said. Responding to another question about possible collaboration with the NMDA, Ms. Blackwell said her understanding is that the NMDA opposes any kind of dental therapist model in New Mexico. Sometimes, organizations need to agree to disagree, offered another member, adding that it is going to take political courage to move things forward.

Public Comment

Barbara Webber, executive director of Health Action New Mexico, told committee members that with the PPACA and the expansion of Medicaid in New Mexico, there is a whole shift in the way health is perceived. The momentum must continue, she said, in oral health and in behavioral health, and she is looking to this committee for leadership, Ms. Webber said.

The committee recessed at 5:15 p.m.

Friday, December 20

Welcome and Introductions

Representative Madalena reconvened the meeting at 8:40 a.m., welcomed guests and asked members and staff to introduce themselves. He also told the day's presenters that their time for presentations would be limited to no more than one hour.

Hospital Funding and County Indigent Funds

Brent Earnest, deputy secretary of the HSD, described the Sole Community Provider (SCP) program, which historically provided additional hospital funding through county contributions, matched by federal funds, to support the principal or sole provider of hospital services in a particular area for uninsured or indigent patients (see handout). Mr. Earnest said that at the end of 2012, the state faced a reduction of more than 70% (from $246 million to $69 million) in the program. Recognizing the severe impact that this would have on SCP hospitals, the HSD proposed a "bridge" payment structure in 2013 that resulted in payments of $159 million. For 2014, the HSD negotiated with the federal Centers for Medicare and Medicaid Services (CMS), through the Centennial Care waiver, a replacement program for this same set of hospitals that includes the following two pools of funding:

- Safety Net Care Pool (funding for uncompensated care and hospital quality care improvements) at $68.8 million for 2014, focused first on smaller hospitals; and
- rate increases for former SCP hospitals.

These changes will alter the distribution of funds based on the amount of services provided by hospitals, Mr. Earnest said. Individual payments to hospitals can no longer be tied

directly to the amount contributed by counties, but instead will be tied more directly to the amount of care provided by those hospitals. To put these payments into effect, the HSD needs a consistent, dedicated revenue stream, and has proposed dedicating an existing one-eighth gross receipts tax (GRT) increment, or the equivalent amount, to this program, Mr. Earnest said. In addition, new general fund appropriations may be necessary to make up the difference, he said. Medicaid expansion should significantly reduce the burden on the county indigent fund programs, he said, as well as reduce uncompensated care at hospitals.

Steven Kopelman, attorney and executive director of the New Mexico Association of Counties, told the committee that counties have always entered into partnerships with their community hospitals, and that the one-eighth GRT increment has always been dedicated to indigent patients who are residents of the county. There are dwindling revenues for counties across the board, Mr. Kopelman said, affecting law enforcement, detention, county roads — everyone is having to make do with less, he said. If the HSD intercepts these county funds, counties could no longer pay for services such as substance abuse programs and ambulance and inmate services, and many counties would have to lay off employees. Counties understand that the HSD needs specific dollar amounts, Mr. Kopelman said, referring committee members to a list of county GRT local option increments as of January 1, 2014 (see handout), but this could be done on a voluntary basis. Part of the problem with the HSD's plan is that it contains a lot of inequities among counties, he said, with some being short-changed and others getting more. But most important is the issue of county autonomy, Mr. Kopelman said. The concept of "intercept" is not acceptable; discretion needs to be given to the counties.

Jeff Dye, president of the New Mexico Hospital Association, provided members with a copy of an editorial by Rich Umbdenstock, president and CEO of the American Hospital Association (see handout), which appeared in the *Wall Street Journal* describing the changing, and challenging, landscape for hospitals of the future. Mr. Dye said the economic impact of downsizing and layoffs in New Mexico's hospitals, which are moving toward providing more primary and outpatient care, is significant. There has been a huge turnover among hospital administrators (39%) during the last year, Mr. Dye said, and lower reimbursements and sequestration have dramatically affected the bottom line. Medicaid reimburses at approximately 58% of the cost of delivering services, he said, and the SCP program has traditionally filled that gap. Finding a new method to make this work will require statutory change, Mr. Dye said. He provided members with a chart of estimated pool and rate increase revenues by hospital (see handout). "We are all in this together," he said, "and we hope we can count on our stakeholder partners".

Questions and Comments

One committee member suggested that instead of asking county programs to "bite the bullet" with an intercept of their funds, the state should create a consistent revenue stream by eliminating corporate tax give-aways and tax breaks for the wealthy. A guest legislator said he asked to be invited to this committee because the two counties in his district are facing a 25% cut in funding for their indigent programs if the one-eighth GRT increment is intercepted. Compared

to the rest of the state, the individuals in his district are very poor, he said, and he has a problem with county dollars being taken away and distributed elsewhere. Another member pointed out that hospitals can enroll new patients in Medicaid at the time of service, and while Mr. Dye agreed that this was so, the process can be time-consuming and cumbersome, he said.

Mr. Earnest agreed with another committee member's comment that the new HSD formula has disparities and that smaller counties benefit more. A member who was a county commissioner before becoming a state legislator told Mr. Earnest and Mr. Dye that the committee recognizes the predicament, and that something reasonable must be done for all involved. Counties today are willing to give more for a reasonable request, the member continued, stating that working together as a team is the only way to accomplish this goal. Santa Fe County alone would lose at least $8 million, the committee member said, and all of its indigent programs would be eliminated. Mr. Earnest responded that he had met with the counties dozens of times, and the HSD is constrained as well, and there is no ability to change much of this. It was the counties who originally created the indigent fund, the member countered, and they have managed it well. Essentially, the HSD is asking for a repeal of the indigent fund, the member stated. Another member asked what will happen to people not poor enough to be on Medicaid but burdened with huge medical bills. Counties are a safety net, Mr. Kopelman responded, and that is why they need to retain these indigent services. At this point, the counties are willing to dedicate a certain amount to the fund, he said. Another member asked for more information about the charts in the handouts, asking for a county-by-county matrix. Mr. Kopelman said that his association has that information, and he will provide it to committee members. Mr. Dye said that the numbers on his handouts were "very soft estimates". Mr. Earnest confirmed that the nature of these numbers only lend themselves to estimates rather than hard numbers. The only hard number is the $68.8 million determined by the CMS, he said.

Community Health Workers

Secretary of Health Retta Ward presented a handout to committee members on the governor's health care work force initiative to create and implement a training program and certification process for community health workers (CHWs). A 2003 senate joint memorial tasked the DOH with a feasibility study of developing a community health advocate program and, in 2006, the New Mexico CHW Advisory Council (see handout) was formed. In 2008, the DOH Office of Community Health Workers was established by executive order, but no funding was allocated for the office. This new initiative to create a certification board and statewide CHW registry includes a request for a recurring $500,000 general fund appropriation, Secretary Ward said. Although CHWs have been serving New Mexico communities for decades, there has been no certification process to ensure basic skills and knowledge. Among the many advantages of competency-based training and certification of CHWs is that many services now will be eligible for reimbursement, she said. CHWs serve as an extension of professional health care providers in frontier and other underserved areas. CHW activities include outreach, community education, informal counseling, social support, referral and advocacy; and CHWs can play a crucial role in reducing health disparities and increasing access to care. There currently are 800 to 900 CHWs (including tribal community health representatives) working in New Mexico, Secretary Ward said.

Questions and Comments

Several members asked about the possibility of inclusion of behavioral health and oral health under the umbrella of CHWs. Christina Carrillo, program manager in the DOH Office of Health Promotion and Community Health Improvement, who accompanied Secretary Ward to the committee hearing, said that the addition of these competencies is being considered, as are other additions. One committee member gave an example of a study he read about where CHWs were utilized in a hospital emergency room and were able to save nurses and physicians a lot of time and save hospitals a lot of money by helping to direct patients to other services of which the patients were unaware. A committee member was concerned that current CHWs be grandfathered into the new program, and Secretary Ward assured the member that this is the case. Ms. Carrillo said the DOH hopes to support the CHW profession as a pathway to other health care careers, as well.

International Community Health Specialists

Francisco Ronquillo, a physician assistant and community health advocate who came to New Mexico from Cuba, spoke to committee members about a work force that exists in New Mexico that currently is vastly underutilized. Mr. Ronquillo was accompanied by a nurse, who also came from Cuba, and a pharmacist who is from Mexico. There is a shortage of health care professionals, Mr. Ronquillo noted, and even though the three cannot practice in their professions in the United States, they would like to at least be able to use their knowledge to help with illness prevention. Jerry Harrison, executive director of New Mexico Health Care Resources, explained that health care professionals such as these are unable to become licensed in New Mexico because, in many cases, they cannot verify their education. Mr. Ronquillo said he has a list of 43 health care professionals in Albuquerque right now. The state could waive certain prerequisites, and credit could be given for those with previous work experience, he said. There are a lot of barriers to licensure here. Mr. Ronquillo said his group has met with the CHW Advisory Council and that UNM has agreed to help with some kind of training program.

Representative Garcia has prepared a house memorial directing UNM HSC to convene a task force to study the potential of using community health specialists for unmet health care needs in New Mexico, and he has asked for the committee's endorsement of Item 25 (202.195349.2) of Appendix A. A motion was made for endorsement; it was seconded and passed with a majority vote.

New Mexico Health Insurance Exchange (NMHIX) Update on Native American Service Center

Mike Nunez, CEO for the NMHIX, provided members of the committee with a written response to questions posed by the committee in a letter dated November 13, 2013 regarding the progress of NMHIX plans for a Native American Service Center (see handout). Mr. Nunez' response provides details of the original grant application to the federal government asking for $1,288,000, broken down as follows:

- tribal support center director $110,000
- tribal support center program managers (2) $150,000
- "fringe benefits" for the positions above $ 78,000
- tribal consultation $337,500
- tribal outreach/education $265,000
- assistance to tribal individuals and small businesses and coverage for appeals and complaints $347,500.

The initial grant was received by the HSD, the letter states, but the funds were not transferred to the NMHIX until November 13, 2013, less expenses for information technology, some minor HSD salary and operations expenses, contracts with the New Mexico Health Insurance Alliance and board start-up activities. Prior to this transfer, no funds had been spent on NMHIX matters related to Native Americans, Mr. Nunez' letter states. In August 2013, following a request-for-information process, a contract was awarded to Native American Professional Parent Resources (NAPPR) to develop a comprehensive outreach, education and enrollment system and to get trained health care guides into the field to do aggressive outreach and enrollment activities, the letter states. As of the end of October 2013, contracts had been developed with all tribes and pueblos, but the Navajo Nation contract is still pending. An additional $1.4 million for Native American Service Center activities and marketing has been requested in a second federal grant submitted on November 15, 2013. To date, funds being spent on Native American activities in 2013 and including those requested for 2014 is $4,441,496. While there is not yet a physical Native American Service Center, Mr. Nunez assured members that these services are being provided by the NMHIX.

Questions and Comments

A member asked Mr. Nunez if the HSD deducted funds from this grant that were not listed as part of the initial grant application. Mr. Nunez said that funds were spent by the HSD in broad classes. The member said that this is of concern to her. Asked about the lack of Navajo participation, Mr. Nunez said there has been some progress through NAPPR outreach, and some chapters are close to an agreement on how outreach and education will occur. Asked how many Native Americans had enrolled in the NMHIX, Mr. Nunez said that two had enrolled through the exchange as of the end of November. Asked about a target goal for Native American enrollments, Mr. Nunez said that number is 2,600. The NMHIX has been greatly hindered by problems with the federal web site, he said.

Another committee member commented on the budgeted salaries for the center director and program managers. Stating that she had been involved in a recent executive director search for another nonprofit entity, these numbers seem out of line for New Mexico. The member also asked for a breakdown of costs for "tribal consultation", and for more detail on the grant budget. Another member asked for details on the fringe benefits, as well. Asked about the vendor selected to build the individual exchange, Mr. Nunez said it is the same vendor that did the Small Business Health Options Program (SHOP), which is doing well. "Get Insured" is the name of the vendor.

Senate Memorial (SM) 94 Task Force Report

Jim Jackson, executive director of Disability Rights New Mexico, and Fletcher Catron, a Santa Fe attorney, provided a detailed report of task force findings (see handout) related to SM 94. Mr. Jackson and Mr. Catron were joined later by John Block III, new executive director of the Developmental Disabilities Planning Council (DDPC). SM 94, sponsored by Senator Ortiz y Pino, requested the DDPC to convene a work group to consider potential changes to the Uniform Probate Code to address issues related to guardianship or conservatorship of incapacitated adults. The issues to be addressed included possible changes to the Uniform Probate Code that would allow greater access by family members to information about decisions and actions of guardians or conservators that could be used to evaluate performance; provide greater accountability to family members for those decisions; and clarify decision-making authority and notice regarding decision-making upon the death of a protected person.

According to the executive summary, task force members generally agreed that, while there may be problems or concerns at times with the way the Uniform Probate Code is applied or administered, it is based on a well-respected national model, and, therefore, amendments should be approached with caution. After careful review of the privacy provisions for the protected person, the task force concluded that confidential information about the protected person should not be automatically provided or available to others simply because they are related to the protected person, as such disclosure may not be in the best interests of the protected person. The task force did recommend that additional funding be provided to the state courts, earmarked for monitoring and review of required annual reports from guardians or conservators, but did not recommend that the Uniform Probate Code be amended to make guardians or conservators more directly accountable to family members. Regarding decision-making authority upon the death of a protected person, the task force recommended that the legislature narrowly amend the code to require that a guardian provide notice of the protected person's death to immediate family members and to provide them with basic information about the process of becoming a personal representative.

The task force's final recommendation was to amend the Uniform Health-Care Decisions Act to allow a health care agent or surrogate, in the absence of an appointed personal representative, to obtain medical records related to the decedent during a 30-day window after an incapacitated person's death.

Questions and Comments

A member asked whether all reports are kept confidential, and was told by Mr. Catron that they are, unless the family members are litigants or there is an order of the court granting access to such records. A family member could petition the court for access if that individual felt it necessary in order to protect the ward, he said. Another member asked Mr. Block what happened in the past when several guardianship contracts were cancelled by the DDPC. Mr. Block responded that the director previous to his directorship sent out a request for proposals (RFP), and later determined that four or five of the responding contractors did not meet contact criteria. There were protests, and another RFP was issued and still no contracts were awarded. After the

director left the council, the Attorney General's Office verified that these contractors did, in fact, have proper qualifications, and they were notified and were allowed to keep the clients they had. Mr. Block, who has been executive director of the council for two months, said his tenure has been a "rocky road" but that things are starting to settle down.

Senator Ortiz y Pino asked the task force members if efforts to amend the Uniform Probate Code and Uniform Health-Care Decisions Act could just as well be postponed until the next session; they agreed that a delay would be fine.

Public Comment

Marcia Southwick, who maintains a Facebook page called Boomers Against Elder Abuse, gave committee members her written statement regarding the need for transparency of the guardianship industry. Virtually every professional involved in a guardianship proceeding stands to benefit financially if an elder can be deemed incapacitated, Ms. Southwick said. In all 50 states, guardianship courts are riddled with these same conflicts of interest, and these courts are referred to by elder advocates as kangaroo courts. Furthermore, as it turns out, there are guardians on the task force who make money off of elders' nest eggs, she said. This is not playing fair when it comes to the most vulnerable members of our society, Ms. Southwick said. In the future, she hopes national advocates will be offered a seat at the table.

Endorsements

See Appendix A for a complete list of all legislation endorsed by the LHHS for the second session of the 2014 legislature.

Adjournment

There being no further business before the committee, the seventh meeting of the 2013 interim LHHS adjourned at 4:45 p.m.